		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041707

Facility Name: Bement Health Care Center

Address: 601 North Morgan Street (Number) Bement (City) 61813 (Zip Code)

County: Piatt

Telephone Number: (217) 678-2191 **Fax #** (217) 678-7521

IDPA ID Number: 371346306001

Date of Initial License for Current Owners: 02/02/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT			x	PROPRIETARY		GOVERNMENTAL
		Charitable Corp.			Individual		State
		Trust			Partnership		County
IRS Exemption Code					Corporation		Other
				x	"Sub-S" Corp.		
					Limited Liability Co.		
					Trust		
					Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	60	Skilled (SNF)	60	21,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	60	TOTALS	60	21,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,062	5,775	1,438	20,275	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,062	5,775	1,438	20,275	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.58%

D. How many bed-hold days during this year were paid by Public Aid?
89 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/02/96

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 02/02/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 8 and days of care provided 1,323

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	88,260	7,675	200	96,135		96,135		96,135			1
2	Food Purchase		79,964		79,964		79,964	(1,608)	78,356			2
3	Housekeeping	41,952	10,720		52,672		52,672		52,672			3
4	Laundry	34,431	4,865		39,296		39,296		39,296			4
5	Heat and Other Utilities			51,930	51,930		51,930	341	52,271			5
6	Maintenance	32,089	20,319	3,305	55,713		55,713	608	56,321			6
7	Other (specify):*											7
8	**TOTAL General Services**	196,732	123,543	55,435	375,710		375,710	(659)	375,051			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	458,660	35,120	1,200	494,980		494,980		494,980			10
10a	Therapy		698	92,000	92,698		92,698		92,698			10a
11	Activities	12,948	411	563	13,922		13,922		13,922			11
12	Social Services	21,310	330	450	22,090		22,090		22,090			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	492,918	36,559	103,213	632,690		632,690		632,690			16
	C. General Administration											
17	Administrative	89,787		20,284	110,071		110,071	(20,284)	89,787			17
18	Directors Fees											18
19	Professional Services			25,569	25,569		25,569	7,465	33,034			19
20	Dues, Fees, Subscriptions & Promotions			3,105	3,105		3,105	456	3,561			20
21	Clerical & General Office Expenses	24,672	2,642	9,634	36,948		36,948	8,539	45,487			21
22	Employee Benefits & Payroll Taxes			125,572	125,572		125,572	11,687	137,259			22
23	Inservice Training & Education			2,612	2,612		2,612	379	2,991			23
24	Travel and Seminar			34,188	34,188		34,188	956	35,144			24
25	Other Admin. Staff Transportation			2,664	2,664		2,664	897	3,561			25
26	Insurance-Prop.Liab.Malpractice			30,504	30,504		30,504	1,375	31,879			26
27	Other (specify):*											27
28	**TOTAL General Administration**	114,459	2,642	254,132	371,233		371,233	11,470	382,703			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	804,109	162,744	412,780	1,379,633		1,379,633	10,811	1,390,444			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Bement Health Care Center #0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			57,577	57,577		57,577	(3,125)	54,452			30
31	Amortization of Pre-Op. & Org.			52,465	52,465		52,465		52,465			31
32	Interest			117,075	117,075		117,075	5,259	122,334			32
33	Real Estate Taxes			31,711	31,711		31,711		31,711			33
34	Rent-Facility & Grounds							2,041	2,041			34
35	Rent-Equipment & Vehicles							310	310			35
36	Other (specify):*											36
37	**TOTAL Ownership**			258,828	258,828		258,828	4,485	263,313			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		18,086		18,086		18,086		18,086			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,850	32,850		32,850		32,850			42
43	Other (specify):* Nonallowable Costs			18,120	18,120		18,120	(18,120)				43
44	**TOTAL Special Cost Centers**		18,086	50,970	69,056		69,056	(18,120)	50,936			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	804,109	180,830	722,578	1,707,517		1,707,517	(2,824)	1,704,693			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(862)	2		4
5	Telephone, TV & Radio in Resident Rooms	(998)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(8,369)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(330)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(50)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,255)	43		24
25	Fund Raising, Advertising and Promotional	(541)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,288)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(7,110)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (29,803)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	26,979		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 26,979		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (2,824)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Bement Health Care Center
Provider # 0041707
12/31/2002

Schedule 5A

VI. Adjustment Detail
Non-Allowable Expenses
Line 29 - Other

Description	Amount	Schedule V Reference
Offset Miscellaneous Income	(1,706)	21
Offset Vending Income	(746)	2
Disallow Special Events	(1,928)	43
Disallow Radiology	(1,365)	43
Disallow Laboratory	(1,365)	43
Total	(7,110)	

See Accountants' Compilation Report

Bement Health Care Center

ID# 0041707

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bement Health Care Center **#** 0041707 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(862)	0	0	0	0	0	0	0	0	0	0	(862)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	341	0	0	0	0	0	0	0	0	0	341	5
6	Maintenance	0	608	0	0	0	0	0	0	0	0	0	608	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(862)	949	0	0	0	0	0	0	0	0	0	87	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(20,284)	0	0	0	0	0	0	0	0	0	(20,284)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,465	0	0	0	0	0	0	0	0	0	7,465	19
20	Fees, Subscriptions & Promotions	0	456	0	0	0	0	0	0	0	0	0	456	20
21	Clerical & General Office Expenses	0	10,245	0	0	0	0	0	0	0	0	0	10,245	21
22	Employee Benefits & Payroll Taxes	0	11,687	0	0	0	0	0	0	0	0	0	11,687	22
23	Inservice Training & Education	0	379	0	0	0	0	0	0	0	0	0	379	23
24	Travel and Seminar	0	956	0	0	0	0	0	0	0	0	0	956	24
25	Other Admin. Staff Transportation	0	897	0	0	0	0	0	0	0	0	0	897	25
26	Insurance-Prop.Liab.Malpractice	0	1,375	0	0	0	0	0	0	0	0	0	1,375	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	13,176	0	0	0	0	0	0	0	0	0	13,176	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(862)	14,125	0	0	0	0	0	0	0	0	0	13,263	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Bement Health Care Center # 0041707 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(8,369)	5,244	0	0	0	0	0	0	0	0	0	(3,125)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	5,259	0	0	0	0	0	0	0	0	0	5,259	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	2,041	0	0	0	0	0	0	0	0	2,041	34
35	Rent-Equipment & Vehicles	0	0	310	0	0	0	0	0	0	0	0	310	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,369)	10,503	2,351	0	0	0	0	0	0	0	0	4,485	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(13,462)	0	0	0	0	0	0	0	0	0	0	(13,462)	43
44	**TOTAL Special Cost Centers**	(13,462)	0	0	0	0	0	0	0	0	0	0	(13,462)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(22,693)	24,628	2,351	0	0	0	0	0	0	0	0	4,286	45

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Petersen	See Sch 6A	See Attached Schedule 6A		See Attached Schedule 6A		
Mark Petersen	See Sch 6A					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Petersen Health Care Companies	0.00%	$ 341	$ 341	1
2	V	6	Maintenance		Petersen Health Care Companies	0.00%	608	608	2
3	V	17	Administrative	20,284	Petersen Health Care Companies	0.00%		(20,284)	3
4	V	19	Professional Services		Petersen Health Care Companies	0.00%	7,465	7,465	4
5	V	20	Dues, Fees, & Subscriptions		Petersen Health Care Companies	0.00%	456	456	5
6	V	21	Clerical & General Office		Petersen Health Care Companies	0.00%	10,245	10,245	6
7	V	22	Employee Benefits		Petersen Health Care Companies	0.00%	11,687	11,687	7
8	V	23	Inservice Training		Petersen Health Care Companies	0.00%	379	379	8
9	V	24	Travel & Seminar		Petersen Health Care Companies	0.00%	956	956	9
10	V	25	Other Admin Staff Transport.		Petersen Health Care Companies	0.00%	897	897	10
11	V	26	Insurance		Petersen Health Care Companies	0.00%	1,375	1,375	11
12	V	30	Depreciation		Petersen Health Care Companies	0.00%	5,244	5,244	12
13	V	32	Interest		Petersen Health Care Companies	0.00%	5,259	5,259	13
14	Total			$ 20,284			$ 44,912	$ * 24,628	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Bement Health Care Center
Provider # 0041707
12/31/2002

Schedule 6A

VII Related Parties-Page 6

Related Nursing Homes	City		Ownership Percentag 01/01/2002 08/30/02	08/31/02 12/31/02
Robings Manor Nursing Home	Brighton, IL	James Petersen	60%	0%
Countryview Terrace	Louisville, IL	Mark Petersen	40%	100%
Sunset Manor Nursing Home	Canton, IL			
Kewanee Care Home	Kewanee, IL			
Arcola Health Care Center	Arcola, IL			
Eastview Terrace	Sullivan, IL			
Havana Health Care Center	Havana, IL			
Palm Terrace of Mattoon	Mattoon, IL			
Bement Health Care Center	Bement, IL			
Prairie City Health Care Center	Prairie City, IL*			
Out of State Nursing Home				
Friendly Village	Rhinelander, WI*			
Horizons Unlimited	Rhinelander, WI*			
Taylor Park	Rhinelander, WI*			
Passport	Rhinelander, WI*			
Meadow Lawn Nursing Center	Davenport, IA			
Cumberland Heights-Tomahawk	Tomahawk, WI*			
Maple Park	Rhinelander, WI*			
Opportunities Unlimited (Workshop setup, no beds)				
Other Related Business Entities				
Petersen Health Care Companies	Peoria, IL Management/ Bookkeeping			
Petersen Property	Canton, IL Building-Sunset Manor			
Related Assisted Living				
Courtyard Estates	Kewanee,IL			

* Not affiliated after 08/30/02

See Accountants' Compilation Report

e

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent-Facility & Grounds	$	Petersen Health Care Companies	0.00%	$ 2,041	$ 2,041	15
16	V	35	Rent-Equipment & Vehicles		Petersen Health Care Companies	0.00%	310	310	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 2,351	$ * 2,351	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	James Petersen	Ex-President	Administrative	See Sch 6A	305,395	4.5	9.00	Salary	$ 29,605	L17, C1	1
2	Mark Petersen	President	Administrative	See Sch 6A	113,953	4.5	9.00	Salary	11,047	L17, C1	2
3	Mark Petersen	Administrative	Administrative	See Sch 6A	114,685	4.5	9.00	Salary	11,135	L17, C1	3
4	Todd Petersen	Administrative	Administrative	See Sch 6A	62,029	4.5	9.00	Salary	6,013	L21, C1	4
5											5
6											6
7											7
8					See Attached Schedule 7A						8
9											9
10											10
11											11
12											12
13								TOTAL	$ 57,800		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Bement Health Care Center
Provider # 0041707
12/31/2002

Schedule 7A

VII. Related Parties (continued)
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.
Compensation Received From Other Nursing Homes

Name	Kewanee Care Center	Country View Terrace	Eastview Terrace	Arcola Health Care	Meadow Lawn Nursing	Robings Manor	Sunset Manor	Havana Care Center	Palm Terrace of Mattoon	Prairie City	Total	Bement Health Care	Grand Total
James Petersen	39,308	8,487	29,671	50,451	33,470	34,462	54,493	40,847	5,410	8,796	305,395	29,605	335,000
Mark Petersen	14,668	3,166	11,071	18,825	12,489	12,859	20,333	15,242	2,018	3,282	113,953	11,047	125,000
Mark Petersen - Administrative	14,785	3,192	11,160	18,976	12,589	12,962	20,496	15,363	2,034	3,308	114,865	11,135	126,000
Todd Petersen	7,984	1,724	6,027	10,247	6,798	7,000	11,068	8,297	1,097	1,787	62,029	6,013	68,042
Total Compensation Received From Other Nursing Homes	76,745	16,569	57,929	98,499	65,346	67,283	106,390	79,749	10,559	17,173	596,242	57,800	654,042

See Accountants' Compilation Report

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, Illinois 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	229,422	11	$ 3,858	$	20,275	$ 341	1
2	6	Maintenance	Patient Days	229,422	11	6,877		20,275	608	2
3	19	Professional Services	Patient Days	229,422	11	84,471		20,275	7,465	3
4	20	Dues, Fees & Subscriptions	Patient Days	229,422	11	5,163		20,275	456	4
5	21	Clerical & General Office	Patient Days	229,422	11	115,931		20,275	10,245	5
6	22	Employee Benefits	Patient Days	229,422	11	132,243		20,275	11,687	6
7	23	Inservice Training	Patient Days	229,422	11	4,287		20,275	379	7
8	24	Travel & Seminar	Patient Days	229,422	11	10,813		20,275	956	8
9	25	Other Admin Staff Transport.	Patient Days	229,422	11	10,154		20,275	897	9
10	26	Insurance	Patient Days	229,422	11	15,558		20,275	1,375	10
11	30	Depreciation	Patient Days	229,422	11	59,343		20,275	5,244	11
12	32	Interest	Patient Days	229,422	11	59,511		20,275	5,259	12
13	34	Rent-Facility & Grounds	Patient Days	229,422	11	23,100		20,275	2,041	13
14	35	Rent-Equipment & Vehicles	Patient Days	229,422	11	3,511		20,275	310	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 534,820	$		$ 47,263	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		x	Mortgage	$1,946.56	08/31/02	$ 1,797,235	$ 1,789,449	08/01/07	varies	$ 101,233	1
2	Bank of Farmington		x	Van Purchase	$997.95	07/31/01	35,926	18,961	08/30/04	0.0875	1,274	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank		x	Line of Credit	Interest Only	08/31/02	155,928	155,928	08/31/03	Varies	13,308	6
7	Adkins Commercial Brokerage		x	Commission Note	$167.00	09/10/96	22,500	10,479	08/10/06	0.0900	1,260	7
8												8
9	TOTAL Facility Related				$3,111.51		$ 2,011,589	$ 1,974,817			$ 117,075	9
	B. Non-Facility Related*											
10								Home Office Allocation			5,259	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 5,259	14
15	TOTALS (line 9+line14)						$ 2,011,589	$ 1,974,817			$ 122,334	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.		$ 29,172	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2001	$ 30,442	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,270	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 30,441	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 31,711	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	27,195	8
	1998	28,054	9
	1999	28,964	10
	2000	29,172	11
	2001	30,442	12

Accrual is equal to 100% of the 2001 Real Estate Tax Bill $30,442

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bement Health Care Center COUNTY Piatt

FACILITY IDPH LICENSE NUMBER 0041707

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (217) 678-2191 FAX #: (217) 678-7521

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	01-00-07-000-609-00	Bement Health Care Center	$ 30,442.00	$ 30,442.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 30,442.00	$ 30,442.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

See Accountants' Compilation Report

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,000 B. General Construction Type: Exterior Block Frame Wood Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	109,829	1996	$ 33,600	1
2					2
3	TOTALS	109,829		$ 33,600	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1996		$ 780,146	$ 20,004	35	$ 22,290	$ 2,286	$ 154,173	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Landscaping			1996	3,650	217	20	183	(34)	1,207	9
10	Parking Lot			1996	1,669	99	20	83	(16)	520	10
11	Driveway			1996	1,050	62	20	53	(9)	345	11
12	Painting and Remodeling			1996	3,155	282	20	158	(124)	1,027	12
13	Curtains			1996	4,928	440	20	246	(194)	1,619	13
14	Walkway			1996	361	9	20	18	9	120	14
15	Alarm and Fire Equipment			1996	4,437	396	20	222	(174)	1,462	15
16	Sign			1996	434	39	20	22	(17)	168	16
17	Heating and Unit Platform			1996	1,219	109	20	61	(48)	478	17
18	300 Gallon Tank			1997	1,370	35	20	69	34	414	18
19	Install Gas Line			1997	1,861	48	20	93	45	543	19
20	Steel Door			1997	1,170	30	20	59	29	344	20
21	New Gas Line			1997	1,875	48	20	94	46	494	21
22	Gas Water Heater			1997	5,008	128	20	250	122	1,292	22
23	Zone Line Heaters			1997	730	65	20	37	(28)	207	23
24	Zone Line Heaters			1997	754	67	20	38	(29)	203	24
25	Generator Repair			1997	6,112		20	306	306	1,556	25
26	Ase Blacktop			1998	10,062	619	20	503	(116)	2,264	26
27	Electrical Service Generator Work			1998	1,846	47	20	92	45	414	27
28	Zone Line Heaters			1998	716	67	20	36	(31)	162	28
29	Heater			1999	4,956	619	20	248	(371)	868	29
30	Kickplates, Handrails			1999	1,803	46	20	90	44	315	30
31	Grade Driveway and Parking Lot			1999	3,100	239	20	155	(84)	543	31
32	Parking Lot Sealant			1999	1,060	82	20	53	(29)	186	32
33	Garage			2000	8,892	228	20	445	217	1,112	33
34	Door Frame Protectors			2000	1,059	27	20	53	26	132	34
35	Nine Windows			2000	2,290	59	20	114	55	285	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Zone Line Heater	2000	$ 1,312	$ 230	20	$ 66	$ (164)	$ 165	37
38	Carpet	2001	1,297	318	7	185	(133)	278	38
39	Fire system	2001	22,829	585	39	585		878	39
40	Air System	2001	9,985	256	39	256		384	40
41	Fire Door	2001	825	21	39	22	1	33	41
42	Water Heater	2002	3,976	1,590	39	51	(1,539)	51	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 895,937	$ 27,111		$ 27,236	$ 125	$ 174,242	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 143,797	$ 16,539	$ 15,485	$ (1,054)	10	$ 85,793	71
72	Current Year Purchases	1,863	820	187	(633)	10	187	72
73	Fully Depreciated Assets							73
74	Allocated from Management Co.			5,244	5,244			74
75	TOTALS	$ 145,660	$ 17,359	$ 20,916	$ 3,557		$ 85,980	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	95 Dodge Truck	2001	$ 31,500	$ 10,080	$ 6,300	$ (3,780)	5	$ 9,450	76
77										77
78										78
79										79
80	TOTALS			$ 31,500	$ 10,080	$ 6,300	$ (3,780)		$ 9,450	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,106,697	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 54,550	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 54,452	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (98)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 269,672	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6		Allocated from Mangement Company			2,041			6
7	TOTAL				$ 2,041 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 310 Description: Home Office Allocation - $310
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
[ ] YES
[X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	2,469	$ 41,974	$	2,469	$ 41,974	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		169	5,926		169	5,926	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C2, C3	hrs		2,450	44,100	698	2,450	44,798	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,C2	# of prescrpts				18,086		18,086	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	5,088	$ 92,000	$ 18,784	5,088	$ 110,784	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Bement Health Care Center
Provider #: 0041707
01/01/02 to 12/31/02

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

See Accountants' Compilation Report

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 22,550	$ 22,550	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	180,929	180,929	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	60,478	60,478	6
7	Other Prepaid Expenses	7,678	7,678	7
8	Accounts Receivable (owners or related parties)	554,208	554,208	8
9	Other(specify): See Schedule 17A	96,475	96,475	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 922,318	$ 922,318	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	33,600	33,600	13
14	Buildings, at Historical Cost	904,919	895,937	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	177,160	177,160	16
17	Accumulated Depreciation (book methods)	(313,348)	(269,672)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Interco - PHC	116,951	116,951	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 919,282	$ 953,976	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,841,600	$ 1,876,294	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 243,390	$ 243,390	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	155,928	155,928	29
30	Accrued Salaries Payable	31,571	31,571	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,441	30,441	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	127	127	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 461,457	$ 461,457	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	29,440	29,440	39
40	Mortgage Payable	1,789,449	1,789,449	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,818,889	$ 1,818,889	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,280,346	$ 2,280,346	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (438,746)	$ (404,052)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,841,600	$ 1,876,294	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Bement Health Care Center
Provider # 0041707
12/31/2002

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

A. Current Assets - Line 9

	Operating	After Consolidation
Accrued Insurance	28,463	28,463
Accrued Expense-Other	57,125	57,125
Accrued State Replacement Tax	10,887	10,887
	96,475	96,475

C. Other Current Liabilities - Line 36

	Operating	After Consolidation
Accrued Sales Tax	73	73
Accrued Interest	54	54
Total	127	127

See Accountants' Compilation Report

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (407,009)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	11,537	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (395,472)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	426,176	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(469,450)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (43,274)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (438,746)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,078,040	1
2	Discounts and Allowances for all Levels	(4,568)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,073,472	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	56,465	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 56,465	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	862	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 862	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	2,894	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,894	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,133,693	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	375,710	31
32	Health Care	632,690	32
33	General Administration	371,233	33
	B. Capital Expense		
34	Ownership	258,828	34
	C. Ancillary Expense		
35	Special Cost Centers	36,206	35
36	Provider Participation Fee	32,850	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,707,517	40
41	**Income before Income Taxes (line 30 minus line 40)****	426,176	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 426,176	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Bement Health Care Center
Provider # 0041707
12/31/2002

Schedule 19A

XVII. INCOME STATEMENT
Revenue - Line 28

E. Other Revenue (specify):	Amount
Transportation	442
Vending	746
Miscellaneous	1,706
	2,894

See Accountants' Compilation Report

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 38,400	$ 18.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,864	5,048	86,983	17.23	3
4	Licensed Practical Nurses	4,333	4,491	55,300	12.31	4
5	Nurse Aides & Orderlies	26,264	27,294	248,217	9.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,181	1,181	10,331	8.75	9
10	Activity Assistants	176	240	2,617	10.90	10
11	Social Service Workers	2,080	2,080	21,310	10.25	11
12	Dietician					12
13	Food Service Supervisor	2,406	2,406	23,157	9.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,086	9,428	65,103	6.91	15
16	Dishwashers					16
17	Maintenance Workers	2,417	2,417	32,089	13.28	17
18	Housekeepers	6,516	6,582	41,952	6.37	18
19	Laundry	4,790	5,012	34,431	6.87	19
20	Administrator	2,371	2,371	89,787	37.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,146	1,150	24,672	21.45	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca Care Plan Coord	1,560	1,560	29,760	19.08	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	71,270	73,340	$ 804,109 *	$ 10.96	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	4	$ 200	L1, C3	35
36	Medical Director	Monthly	9,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	563	L11, C3	44
45	Social Service Consultant	18	450	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	45	$ 11,413		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Angela Edwards	Administrator	0%	$ 38,000
Mark Petersen	Administrative	Sch 6A	11,047
James Petersen	Administrative	Sch 6A	29,605
Mark Petersen	Administrative	Sch 6A	11,135
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,787

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 20,284
TOTAL (agree to Schedule V, line 17, col. 3)	$ 20,284
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Bush & Snyder	Legal	$ 528
Ginoli & Co.	Accounting	5,333
Altschuler, Melvoin & Glasser	Accounting	7,300
AMEX Tax & Business Services	Accounting	970
ADP	Payroll	7,416
America Online	Computer Services	300
LTC Solutions	Computer Services	2,820
Insight Communications	Computer Services	224
Ivans	Computer Services	344
Rudy Hadsell	Computer Services	334
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 25,569

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,515
Unemployment Compensation Insurance	9,483
FICA Taxes	53,552
Employee Health Insurance	29,584
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	849
Employee Relations	8,295
Life Insurance	294
Allocated from Management Company	11,687
TOTAL (agree to Schedule V, line 22, col.8)	$ 137,259

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	345
Health Care Worker Background Check	
(Indicate # of checks performed 58)	696
Illinois Health Care Association	1,656
Miscellaneous Dues & Subscriptions	283
Miscellaneous License & Fees	125
Allocated from Management Company	456
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,561

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	33,773
Seminar Expense	415
Home Office Allocation	956
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 35,144

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Bement Health Care Center
Provider #: 0041707
01/01/02 to 12/31/02

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	25,569
Allocated from Management Company	
Other Professional Fees	6,737
Legal	728
Total (agree to Schedule V, line 19, column 8)	33,034

See Accountants' Compilation Report

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9							N/A						
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Bement Health Care Center # 0041707 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $1,656**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **9,420** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **32,850**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **No** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **862**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **Yes** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **442**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Company** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Bement Health Care Center
Provider #: 0041707
12/31/2002

Inservice Training and Education

Parkland College	Pam Lanter	228
Continental Testing	Angela Edward	134
SIU	CNA Test	250
Scholarship Money	Heather Mulvaney	2,000
		2,612
	Allocation from Management Co.	379
		2,991

See Accountants' Compilation Report

RECONCILIATION REPORT **Bement Health Care Cen** **02:14 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-2,824	equal to	-2,824	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	122,334	equal to	122,334	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	31,711	equal to	31,711	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	52,465	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	54,452	equal to	54,452	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	2,041	equal to	2,041	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	310	equal to	310	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	92,698	equal to	92,698	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	18,784	equal to	18,784	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	375,710	equal to	375,710	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	632,690	equal to	632,690	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	371,233	equal to	371,233	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	258,828	equal to	258,828	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	36,206	equal to	36,206	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	32,850	equal to	32,850	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	428,900	equal to	458,660	-29,760	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	12,948	equal to	12,948	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	21,310	equal to	21,310	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	88,260	equal to	88,260	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	32,089	equal to	32,089	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	41,952	equal to	41,952	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	34,431	equal to	34,431	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	89,787	equal to	89,787	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	24,672	equal to	24,672	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	804,109	equal to	804,109	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	200	< or = to	200	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	9,000	< or = to	9,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,200	< or = to	1,200	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	563	< or = to	563	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	450	< or = to	450	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	89,787	equal to	89,787	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	20,284	equal to	20,284	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	25,569	equal to	25,569	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	137,259	equal to	137,259	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	3,561	equal to	3,561	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	35,144	equal to	35,144	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	32,850	equal to	32,850	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	No	< or = to	11,687	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	No	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,323	equal to	1,438	-115	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	26,979	equal to	26,979	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	1,974,817	equal to	1,974,817	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	30,441	equal to	30,441	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	33,600	equal to	33,600	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	895,937	equal to	895,937	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	177,160	equal to	177,160	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	269,672	equal to	269,672	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-438,746	equal to	-438,746	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	426,176	equal to	426,176	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,841,600	equal to	1,841,600	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Cell: E22
Comment: Tanalee:
Care Plan Coordinator is at the bottom of the schedule.

Cell: E50
Comment: Tanalee:
Difference is private days

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	88,260	7,675	200	96,135	0	96,135	0	96,135
2. Food P	0	79,964	0	79,964	0	79,964	-1,608	78,356
3. Housek	41,952	10,720	0	52,672	0	52,672	0	52,672
4. Laundry	34,431	4,865	0	39,296	0	39,296	0	39,296
5. Heat ar	0	0	51,930	51,930	0	51,930	341	52,271
6. Mainter	32,089	20,319	3,305	55,713	0	55,713	608	56,321
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	196,732	123,543	55,435	375,710	0	375,710	-659	375,051
9. Medical	0	0	9,000	9,000	0	9,000	0	9,000
10. Nursin	458,660	35,120	1,200	494,980	0	494,980	0	494,980
10a. Thera	0	698	92,000	92,698	0	92,698	0	92,698
11. Activiti	12,948	411	563	13,922	0	13,922	0	13,922
12. Social	21,310	330	450	22,090	0	22,090	0	22,090
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	492,918	36,559	103,213	632,690	0	632,690	0	632,690
17. Admin	89,787	0	20,284	110,071	0	110,071	-20,284	89,787
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	25,569	25,569	0	25,569	7,465	33,034
20. Fees,	0	0	3,105	3,105	0	3,105	456	3,561
21. Clerica	24,672	2,642	9,634	36,948	0	36,948	8,539	45,487
22. Emplo	0	0	125,572	125,572	0	125,572	11,687	137,259
23. Inserv	0	0	2,612	2,612	0	2,612	379	2,991
24. Travel	0	0	34,188	34,188	0	34,188	956	35,144
25. Other	0	0	2,664	2,664	0	2,664	897	3,561
26. Insura	0	0	30,504	30,504	0	30,504	1,375	31,879
27. Other	0	0	0	0	0	0	0	0
28. Total (	114,459	2,642	254,132	371,233	0	371,233	11,470	382,703
29. Total (	804,109	162,744	412,780	1,379,633	0	1,379,633	10,811	1,390,444
30. Depre	0	0	57,577	57,577	0	57,577	-3,125	54,452
31. Amorti	0	0	52,465	52,465	0	52,465	0	52,465
32. Interes	0	0	117,075	117,075	0	117,075	5,259	122,334
33. Real E	0	0	31,711	31,711	0	31,711	0	31,711
34. Rent -	0	0	0	0	0	0	2,041	2,041
35. Rent -	0	0	0	0	0	0	310	310
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	258,828	258,828	0	258,828	4,485	263,313
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	18,086	0	18,086	0	18,086	0	18,086
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	32,850	32,850	0	32,850	0	32,850
43. Other	0	0	18,120	18,120	0	18,120	-18,120	0
44. Total S	0	18,086	50,970	69,056	0	69,056	-18,120	50,936
45. Grand	804,109	180,830	722,578	1,707,517	0	1,707,517	-2,824	1,704,693

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	22,550	22,550
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	180,929	180,929
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	60,478	60,478
7. Other Prepaid Expenses	7,678	7,678
8. Accounts Receivable-Owner/Related Party	554,208	554,208
9. Other (specify):	96,475	96,475
10. Total current assets	922,318	922,318
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	33,600	33,600
14. Buildings, at Historical Cost	904,919	895,937
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	177,160	177,160
17. Accumulated Depreciation (book methods)	-313,348	-269,672
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	116,951	116,951
24. Total Long-Term Assets	919,282	953,976
25. Total Assets	1,841,600	1,876,294
CURRENT LIABILITIES		
26. Accounts Payable	243,390	243,390
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	155,928	155,928
30. Accrued Salaries Payable	31,571	31,571
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	30,441	30,441
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	127	127
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	461,457	461,457
LONG TERM LIABILITES		
39.Long-Term Notes Payable	29,440	29,440
40.Mortgage Payable	1,789,449	1,789,449
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,818,889	1,818,889
46.Total Liabilities	2,280,346	2,280,346
47.Total Equity	-438,746	-404,052
48.Total Liabilities and Equity	1,841,600	1,876,294

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,078,040
2. Discounts and Allowances for all Levels	-4,568
Subtotal - Inpatient Care	2,073,472
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	56,465
7. Oxygen	0
Subtotal - Anciliary Revenue	56,465
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	862
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	862
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	2,894
28. Other Revenue (specify):	0
Subtotal - Other Revenue	2,894
30. Total Revenue	2,133,693
31. General Services	375,710
32. Health Care	632,690
33. General Administration	371,233
34. Ownership	258,828
35. Special Cost Centers	36,206
35. Provider Participation Fee	32,850
37. Other	0
40. Total Expenses	1,707,517
41. Income Before Income Taxes	426,176
42. Income Taxes	0
43. Net Income or Loss for the Year	426,176

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Line 16 for mortgage insurance.